NEW QUALITY INFORMATION DEVELOPMENT

Purpose: To identify ways in which the State can improve the quality- related information collected and available for consumers, providers, health plans, employers , policy makers and others.

EXECUTIVE SUMMARY

A well-informed and well-educated public with appropriate choice and access to quality health care is key to improved health. The current array of health care quality information is insufficient. Limitations include:

1. Comparative data are scarce and paper charts are not amenable to large-scale quality of care evaluations.
2. Risk adjustment is needed to level the playing field for analyzing clinical outcomes, and to reduce adverse selection.
3. Consumers, patients and purchasers do not have enough of the right sorts of information necessary to make informed decisions about health care options related to treatments, providers, plans (i.e., health insurance arrangements, also known as health benefits financial intermediaries) or carriers.
4. Providers are hampered in their ability to deliver care with excellent outcomes by limited data to support evidence based medicine.
5. State efforts at data collection are limited by sometimes problematic legislative oversight, confinement to the hospital discharge abstract and long reporting cycles.

These limitations impede the timeliness and usefulness of resulting information. To improve these shortcomings we recommend the following actions. Wherever possible, efforts should be coordinated among all levels of government and with the private sector.

Recommendations

1. Pilot test risk adjusted payments as well as performance and outcome evaluations.

Without adequate risk adjustment it is difficult to fairly assess performance between providers and health care organizations. And without compensating providers and organizations according to risk adjusted patient load severity, we can unintentionally penalize the better performers by steering sicker, more costly patients to them. There is a need to encourage physicians and health plans to treat high-risk patients by compensating them accordingly. (For more detailed discussion, please see the Risk Adjustment paper.)

The State should explore partnering with HCFA in developing a demonstration project to test risk adjusted payments and performance and outcome evaluations in the Medi-Cal program. Simultaneously, State regulators should encourage analogous projects in the commercial market.

2. Advance implementation of electronic records. Paper charts are not amenable to large-scale quality of care evaluations.

The State should establish a public/private task force of consumers, purchasers and providers to recommend by 1999 a statewide strategy for implementing electronic medical records to improve the quality of care across California. The State should require that electronic records be phased in by 2002-2004 depending on the size and resources of the medical groups, health plans, clinics and hospitals. This strategy should include provisions for maintaining patient confidentiality.

3. Improve the flexibility of State health data programs to support new quality information initiatives at present and into the future.

The State should transition from a statutory to a regulatory approach to health data collection. The legislature should set broad data guidelines and authorize a public/private body or "blue ribbon" advisory group to choose specific data elements and balance the trade-off between the cost and value of information. Among the questions this group should address: How can we encourage construction of the technology and underlying hardware to support the information environment we would like to develop in California? Should we simply recommend that certain information be collected by some date in the future? Should the data be in a form that must be compatible for multiple users? Should the data be a requirement for doing business? Should we let the private sector devise the hardware/platform solutions? Public/private collective action is needed to implement these goals.

4. Collect health information at the treatment level

Quality information should be collected and disseminated not only at the plan level, but also at the treatment level, including hospital, medical group, ambulatory center and nursing home levels. Information should also be reported by local geographic area where people are likely to seek and receive health care services. All information should emphasize and compare outcomes. Data measurements should be statistically sound and performed if they improve the quality of care and choice.

5. Study and report key information publicly

Specific studies should be undertaken by the State (or under private contract) for comparative performance analysis to be made broadly available to the public and should include the following topics. In all cases, measurement methods need to be developed or improved.

1. Study and report by health plan:
   - Which health plans use available outcome data to choose hospitals, medical groups, providers and other facilities for their network? How are decisions made? What are the benefits to the public? Why do some plans use low volume hospitals for volume-sensitive procedures?

- Study and report which health plans receive and evaluate patient encounter data. Look for improvement in patterns of care to verify quality of care and to suggest enhancements.

2. Study and report by medical group/IPA:
   - Who detects cancers at the earliest most treatable stages and achieves the best risk adjusted survival outcomes? Measurement methods need to be developed.
   - Who does the best job of changing patients' health behaviors such as smoking?
   - Who does the best job of improving physiological scores such as lowering high blood pressure and high cholesterol?
   - Who does the best job of improving functional outcomes for adults and children with chronic disease?
   - Who does the best job of providing prenatal care, and achieving the best risk adjusted perinatal outcomes?
   - Who does the best job of improving functional outcomes for individuals with depression or other mental health conditions?
3. Study and report by hospital who does the best job with risk adjusted outcomes for certain procedures and conditions such as myocardial infarction (MI), major gastrointestinal surgery, coronary artery bypass graft (CABG) and autologous bone marrow transplant (ABMT)?
4. Study all of the health plans and their associated hospitals and medical groups to determine who does the best job of involving patients in treatment decision making through education and respecting patient preferences.

6. Ensure basic safety standards for patient care

There are some instances when quality information should be monitored to ensure the basic safety of the public. Collecting, monitoring, auditing and most of all improving clinical care based on these data serves a greater public good and should be encouraged by public regulation and required by private accreditation. Continuous customer feedback should be used to determine which studies are or are not useful, and to continuously improve the value of the information collected. Such basic safety data in addition to those contained in the California Health and Safety Code might include:

- infection rates and unplanned re-admission rates for inpatient and outpatient care
- number and rate of adverse drug events for inpatient and outpatient care
- risk adjusted mortality and morbidity for major surgeries and treatments

A "blue ribbon" panel should set maximum acceptable rates for the adverse events listed above to ensure patient safety. If a medical group, hospital or other relevant health care organization can not meet basic standards of patient safety, its patient activity should be appropriately curtailed. Standards should be adjusted periodically to raise the bar of acceptable performance and enhance patient safety. The State, its contractors, or designated private group, should continuously monitor and audit performance.

NEW QUALITY INFORMATION DEVELOPMENT

PHILOSOPHY

Introduction

A well-informed and well-educated public with appropriate choice and access to quality health care is key to improved health. The state government is an entity with institutional stability. It can provide publicly available information that is reliable and verifiable with equal access to all. The State can also provide objective analyses of outcomes of care, access to care and patient satisfaction through collaboration among state agencies and in partnership with the private sector.

The State, in partnership with private sector and other public sector efforts, should provide health information to the following groups for the following purposes:

1. To help California consumers make informed choices about health plans, providers, and treatment options.
2. To help health plans and providers improve the quality of health care by determining what works, when it works and why it works. This information would add to the developing cache of evidence based medicine being pursued by health professionals and researchers.
3. To help public and private purchasers better determine the value derived from their health care purchases.
4. To help policy makers to better safeguard the public's health.

Information as the cornerstone of quality improvement

Physicians and health care organizations will be more supportive of data collection and evaluation efforts if they perceive that information about their performance and outcomes are gathered for purposes of improving the quality of care. For example, shared information about improvements in hip replacement surgery led to reduced patient days in intensive care. Functional outcomes and overall mobility improved more rapidly for patients as well. It also reduced the total days required for hospitalization. [1] Improvements in coronary artery bypass graft surgery (CABG) have been shown to improve patient outcomes and reduce hospital days when a minimum of 200-300 surgeries are done per year. Volume has been correlated with improved outcomes and patients and purchasers should have ready access to this information.[2]

Published clinical outcome data may be at odds with the current tort system and may antagonize lower level performers. This possibility should not deter publishing outcome information or seeking tort reform.

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[1] Keston, V. and Enthoven AC, "Re-Engineering Total Hip Replacement: A Case History of Innovations to Improve Quality while Reducing Cost," Health Care Management Review (forthcoming.)
[2] American College of Cardiology recommendation.

Data and measurements should be statistically sound and only collected if they improve the quality of care or enhance decision making when a choice is involved.

Generating information can be expensive and a cost-benefit evaluation should be conducted before new data are sought. Only information which is useful for improving care or helping consumers and purchasers choose appropriate care and treatments should be collected. Data should be valid, from a credible source and open to audit. It should be collected using uniform standards that avoid duplication.

The State has a responsibility to encourage the creation of the information technology infrastructure to support new quality information initiatives at present and into the future.

Given that almost 50% of health care revenues come from public coffers, fiduciary responsibility requires a far clearer understanding of how these taxpayer dollars are being spent to guarantee efficient distribution for health status improvement. Working with the States, the federal government, supported by private initiatives, should have responsibility for determining national standards for technology and for privacy and confidentiality protections. For example the federal government sets the standard for 87-octane gasoline so that whether you fill your gas tank in California or Florida, the basic composition of the gasoline is the same. How can we encourage construction of the technology and underlying hardware to support the information environment we would like to develop in California? Should we simply recommend that certain information be collected by some date in the future? Should the data be in a form that must be compatible for multiple users? Should the data be a requirement for doing business? Should we let the private sector devise the hardware/platform solutions? Public/private collective action is needed to implement these goals.

Encourage risk adjustment research and piloting

Without adequate risk adjustment it is difficult to fairly assess performance between providers and health care organizations. And without compensating providers and organizations according to risk adjusted patient load severity, we can unintentionally penalize the better performers by steering sicker, more costly patients to them. There is a need to encourage physicians and health plans to treat high-risk patients by compensating them accordingly.

There are several risk adjustment projects currently in operation. The Health Insurance Plan of California (HIPC) risk adjusts its premiums. Colorado, Missouri and Maryland are also planning to use risk adjusters in new Medicaid managed care contracts. In addition, federal efforts at risk adjustment should also be supported. Medicare is piloting a risk adjustment system called Medicare Choices in 13 communities and based on 2 diagnosis risk adjusters. This type of innovative research should be encouraged.[3]

The State should consider partnering with HCFA in a demonstration project to test risk adjustment payments and performance and outcome evaluations in the Medi-Cal program.

[3] Newhouse, JP., Buntin, MB., and Chapman, JD., "Risk Adjustment And Medicare: Taking A Closer Look." Health Affairs, vol. 16, Number 3, pp. 26-43.

Move from paper records to electronic records.

Evaluating and improving the entire continuum of care requires clinical information that is too costly and ponderous to collect with paper charts. A variety of electronic media including intranet, internet, smart card technologies and others in development should be considered as vehicles for collecting and distributing health care information.

The State should establish a public/private task force of consumers, purchasers and providers to recommend by 1999 a statewide strategy for implementing electronic medical records across California. The State should require that electronic records be phased in by 2002-2004 for medical groups and health plans, depending on their size and resources.

The federal government should assume responsibility for: establishing technical standards for electronic communication of health care information; standards for confidentiality; and standards for information security. Federal initiatives in these areas will help insure compatibility and comparability of information across states. This will assist the study of health outcomes regionally and nationally.

"IMPROVING HEALTH INFORMATION FOR THE BENEFIT OF ALL CALIFORNIANS" (SENATE BILL 1109 REPORT)[4]

The Managed Health Care Improvement Task Force wishes to endorse the report "Improving Health Information for the Benefit of All Californians" and support the recommended research and activities of the Commission. The report recognizes that medical care is no longer delivered just in the hospital. Services are being delivered in outpatient centers, offices, homes and ever evolving new settings across a continuum of care. The report advocates government action to reduce the cycle times of repeated reports. It also recommends reducing legislative control over data collection. This would be consistent with a move from statutory to regulatory oversight. We agree with this shift. The Commission report also suggests that uniform identifiers for patients and uniform language and definitions should be identified at the federal level to ensure national compatibility and comparability. It also recommends increased use of technology for data reporting.

In addition, the Commission felt strongly that there should be federal involvement in developing patient privacy and confidentiality protections. Strong fire walls are needed to ensure privacy for patients. Fire walls should not be put in place to protect providers from reasonable accountability for the health care services that they give their patients.

In certain respects the Commission could have gone farther. The report addresses the State's role in technology development. However, it is silent on the private sector's role. The private

[4] SB1109 sponsored by Senator Leslie, signed by Governor Wilson October 4, 1995. Report submitted to OSHPD January 10, 1997, first in a series of legislative packages to be submitted to the legislature January, 1998. Both documents attached as Appendix.

sector's role should be encouraged since they may be the most able to solve the challenging technology problems which are key to collecting and distributing health care information

ENCOURAGE MEANINGFUL COMPARISON OF HEALTH INFORMATION ACROSS HEALTH PLANS AND ACROSS MEDICAL GROUPS

Develop uniform data standards for reporting about prices, performance quality and service.

As mentioned earlier, the State should transition from a statutory to a regulatory approach to health data collection. The legislature should set broad data guidelines but a public/private body or "blue ribbon" advisory group should choose specific data elements and balance the trade-off between the cost and value of information. The "blue ribbon" advisory group should look to existing private sector organizations such as CCHRI, JCAHO, NCQA and FACCT. Their quality and outcome research and development efforts will be helpful in choosing information to collect.

The State should not duplicate data collection efforts. It should encourage the work of the above organizations and facilitate the wide distribution of their results. The State should complement these efforts by collecting and disclosing needed information that is not gathered or disclosed by the private sector.

Beginning with larger employers, provide incentives to these employers to provide employees with plan and medical group performance data for relevant medical groups and insurance products.

We feel that quality information should be collected and disseminated not only at the plan level, but also at the treatment level including hospital, medical group, ambulatory center and nursing home levels. Information should emphasize results and outcomes and should be reported for comparison by local geographic area where people are likely to seek and receive health care services. For example, what a health plan does in southern California is irrelevant to employees in the central valley. The delivery of health care is in many respects a local concern.

Create a "Super Directory" of doctors and hospitals contracting with HMOs. Make it publicly available through a variety of media.

Information is only useful if it is effectively communicated to the people who need it. People learn and process information in a variety of ways. Some of us are auditory learners, some are visual learners and others are kinetic learners. Therefore information about health plans, physician choices, hospital choices, treatment options and health outcomes must be presented and distributed in multiple ways to capture a variety of learning styles. A "Super Directory" should be provided through various technologies to achieve maximum exposure, e.g., on-line, touch-tone phone, paper, videotape and others yet to be invented. Some of this information could be made available through employer's benefit offices, the internet and public libraries. Government action, such as a requirement of licensure, may be required to insure timely updates. Quarterly updates may be desirable.

Study and report key information publicly

To encourage meaningful comparison of health plans, hospitals and medical groups, specific studies should be undertaken for comparative performance analysis by appropriate groups such as RAND and the universities. The following studies could be very worthwhile:

1. Study and report by health plan:
   - Which health plans use available outcome data to choose hospitals, medical groups, providers and other facilities for their network?
   - How are decisions made? What are the benefits to the public?
   - Why do some plans use low volume hospitals for volume-sensitive procedures?
   - Study and report which health plans receive and evaluate patient encounter data. Look for improvement in patterns of care to verify quality of care and to suggest enhancements.
2. Study and report by medical group:
   - Who detects cancers at the earliest most treatable stages, and achieves the best risk adjusted survival outcomes? Measurement methods need to be developed.
   - Who does the best job of changing patients' health behaviors such as smoking?
   - Who does the best job of improving physiological scores such as lowering high blood pressure and high cholesterol?
   - Who does the best job of improving functional outcomes for adults and children with chronic disease?
   - Who does the best job of providing prenatal care, and achieving the best risk adjusted perinatal outcomes?
   - Who does the best job of improving functional outcomes for individuals with depression or other mental health conditions?

1. Study and report by hospital who does the best job with risk adjusted outcomes for certain procedures and conditions such as myocardial infarction (MI), major gastrointestinal surgery, coronary artery bypass graft (CABG), and autologous bone marrow transplant (ABMT)?
2. Study all of the health plans and their associated hospitals and medical groups to determine who does the best job of involving patients in treatment decision making through education and respecting patient preferences.

In all cases, measurement methods need to be developed or improved. When completed, these analyses should me made broadly available to the public.

Ensure basic safety standards for patient care

There are some instances when quality information should be monitored to ensure the basic safety of the public. Collecting, monitoring, auditing and most of all improving clinical care based on these data serves a greater public good and should be encouraged by public regulation and required by private accreditation. Continuous customer feedback should be used to determine which studies are or are not useful, and to continuously improve the value of the information collected. Such basic safety requirements in addition to those contained in the California Health and Safety Code might include:

- infection rates and unplanned re-admission rates for inpatient and outpatient care
- number and rate of adverse drug events for inpatient and outpatient care
- risk adjusted mortality and morbidity for major surgeries and treatments

Standards should be set for the maximum acceptable rates of the adverse events listed above to ensure patient safety. If a medical group, hospital or other relevant health care organization can not meet basic standards of patient safety, patient activity should be appropriately curtailed.

CONCLUSION

New quality information should be developed within a learning cycle of continuous improvement. In order to improve something you need to be able to measure it. To measure something as important as the quality of health care you need an efficient, reliable and cost-effective system for collecting and analyzing important data. The benefits of increasing the current array of health care quality data include:

- Creating better tools for physicians to use to conduct risk adjustment and outcome studies, design clinical pathways and practice guidelines, and generally add to the research and development of evidence based clinical medicine.
- Improving the quality of relevant information made widely available to patients, consumers and employers to help them choose a health plan, doctor, hospital, or treatment.
- Developing more statistically reliable ways of measuring patient and consumer satisfaction with the health care services that they choose.
- Helping policy makers to better safeguard the public's health.

There will be considerable cost attached to expanding and enhancing the information about the quality of health care in California. The investment is necessary if we are to improve the quality of managed health care available. If we do not make this investment, attention will focus on cost and we will know little about value.

To preserve flexibility of the information environment, regulatory rather than statutory oversight should be adopted. Regulatory oversight as well as the tools used to collect and distribute information should be developed by public/private partnerships to encourage technically driven

and market driven innovations. Clear dates and deadlines are necessary to move these initiatives forward. A mechanism for piloting different information initiatives is desirable so that perhaps one or two or more will have value, produce desirable results and earn acceptance in the marketplace. The recommendations proposed in this paper are intended as a starting point. Once implemented they must be evaluated and shown to have proven their worth. Improvement is a dynamic process that must constantly incorporate change, innovation and better ways of insuring the health of the people of California.

Note: For more background detail on currently available quality information please see TASK FORCE ATTACHMENT 1: QUALITY MEASUREMENT & ACCREDITATION

APPENDIX

SB 1109 Report "Improving Health Information for the Benefit of All Californians"

First legislative package to be submitted to the Legislature, January, 1998 to begin implementing SB 1109